St. Joseph Hospital
Orange, CA

Medical Staff Education Packet
2015
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INTRODUCTION

St. Joseph Hospital is accredited by The Joint Commission (TJC) – a non-profit organization that sets minimum standards for quality and safety in healthcare organizations. TJC is also a deemed-status agency authorized by the federal government to certify healthcare organizations as meeting Medicare Conditions of Participation.

TJC standards require that physicians, other licensed independent practitioners, and other members of the medical staff receive education on selected topics. This packet has been developed to meet these requirements.

Please review the information contained in this packet. If you have any questions or concerns, please contact St. Joseph Hospital Medical Staff Office.

TOPICS

ROLE IN THE EVENT OF A FIRE

St. Joseph Hospital has a Fire Response Team that consists of Security Services and Plant Maintenance staff who respond to Code Red Alarms on campus. Activate a Code Red whenever sustained smoke or flame is encountered.

Each floor or wing contains at least two smoke compartments that provide a safe area of refuge with minimal travel distance and prevents the fire from spreading to other areas. If a fire occurs in the immediate area, evacuate horizontally through the double doors to an adjacent smoke compartment, then vertically if necessary.

In the event of a fire remember the acronym R.A.C.E.

- **Rescue** persons in immediate danger
- **Alarm** pull the alarm and dial “66” (dial “911” for offsite locations)
- **Confine** the fire/smoke by closing doors and windows
- **Extinguish/Evacuate** extinguish the fire only if it is safe to do so or Evacuate the area to adjacent smoke compartment.

To extinguish a fire follow the acronym P.A.S.S.

- *Pull* the pin on the extinguisher
- *Aim* low at the base of the fire
- *Squeeze* the lever to discharge the agent
- *Sweep* the nozzle or hose from side to side until the flames appear to be out
**OXYGEN RICH PROCEDURAL AREAS:**

- Prior to every procedure ask four questions to assess the patient’s fire risk:
  1. Alcohol based prep used?
  2. Surgical site or incision above the xiphoid?
  3. Open oxygen source?
  4. Available ignition source?

Each “yes” = 1 point. A score of 3 or 4 is **HIGH RISK FOR FIRE**.

**Key prevention tactics:**

- Ensure prep is dry before draping and/or applying an incise drape
- Ensure prep hasn’t pooled under/around patient
- Oxygen is stopped 1 minute prior to use of the ignition source or titrated to the lowest concentration needed for optimal patient oxygenation
- Tent the drapes to prevent buildup of oxygen
- Have water or saline on the sterile field prior to the start of the procedure

**In the event of fire in an oxygen rich environment:**

- Simultaneously...
- Smother the fire using saline, water, or wet sponges.
- Stop the oxygen delivery
- Remove burning drapes/materials from the patient onto the floor
- Extinguish burning materials by slowly pouring saline or water onto them
- Dial “66” (dial “911” or “9-911” as applicable for offsite locations) for sustained smoke or flame
- Assess patient for injury
- Use a fire extinguisher if unable to extinguish flame
- Prepare for evacuation of the room.

**Water Mist Fire Extinguishers:** It is recommended that a water mist fire extinguisher be used on operating room fires because these units use de-ionized water that will not carry dust throughout the surgical suite. **Water mist fire extinguishers are predominantly for sterile environments.**

**ABC Fire Extinguishers:** Multi-purpose fire extinguishers utilize a dry chemical agent that suppresses Class A, B and C fires. They can be used to extinguish common combustible, flammable liquid and live electrical equipment fires.

**Halon Fire Extinguishers:** Liquefied gas, pressurized with nitrogen, which discharges as a vapor causing no cold or static shock. It suppresses Class A, B, and C fires.
Evacuation of an anesthetized patient

- The Anesthesiologist will maintain the patient’s anesthetic state and collect minimal drugs for transport.
- The Surgeon will control and maintain the surgical wound, pour saline into surgical site and help move the OR table with the patient out of the room.
- The Circulating Nurse or Anesthesia Tech will disconnect gas lines and electrical plugs and help move the anesthesia machine out of the room if the Anesthesiologist determines it is necessary. Otherwise, disconnect the patient’s leads and lines, retrieve the ambu bag and transport the patient.
- The Scrub Nurse will gather minimal instruments into a basin, place on OR table, and help move the patient out of the room.
- The Circulating Nurse will stop flow of anesthesia gases by pulling levers located outside of each surgical suite.
- The last person to leave the operating room will close the door.

RESPONDING TO INCIDENTS IN THE CARE ENVIRONMENT

If you become aware of an unsafe or potentially unsafe situation, please report it immediately to the supervisor of the care or work area. If an incident occurs, please take actions necessary to protect yourself and others from harm and report the incident immediately to the supervisor of the care or work area.

ROLE IN EMERGENCY MANAGEMENT

St. Joseph Hospital has established a comprehensive plan to respond to a variety of emergency situations. In the event of a significant emergency (i.e. Code Triage External), members of the medical staff are to contact the Medical Staff Office for further instructions.

Hospital Emergency Codes

<table>
<thead>
<tr>
<th>Color</th>
<th>Code</th>
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<tbody>
<tr>
<td>Red</td>
<td>Fire</td>
</tr>
<tr>
<td>Yellow</td>
<td>Bomb Threat</td>
</tr>
<tr>
<td>Orange</td>
<td>Hazmat Exposure/Spill</td>
</tr>
<tr>
<td>Blue</td>
<td>Medical Emergency – Adult</td>
</tr>
<tr>
<td>White</td>
<td>Medical Emergency – Child</td>
</tr>
<tr>
<td>Pink</td>
<td>Infant Abduction</td>
</tr>
<tr>
<td>Purple</td>
<td>Child Abduction</td>
</tr>
<tr>
<td>Gray</td>
<td>Assaultive Person</td>
</tr>
<tr>
<td>Silver</td>
<td>Person with a Weapon</td>
</tr>
<tr>
<td>Elope/Green</td>
<td>Eloping Patient</td>
</tr>
<tr>
<td>Triage</td>
<td>Disaster – Internal/External</td>
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<tr>
<td>Triage Standby</td>
<td>Emergency Radio</td>
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NOTE: If any of the codes are announced in the area in which you are, a hospital staff member will assist you in how to respond to the event.
INFECTION PREVENTION AND CONTROL

St. Joseph Hospital is dedicated to promoting patient and staff safety through the prevention and control of infection. Primary strategies toward this task include hand hygiene, Standard Precautions and Transmission-Based Precautions (Contact, Contact (Spore) Precautions, Droplet Precautions, and Airborne Precautions).

Additionally, prevention and control activities include health screening and immunization, active surveillance cultures of patients, proper disposal of medical waste, sharps safety; cleaning and disinfection of equipment, instruments and work areas.

Regulatory and governmental agencies establish requirements to which hospitals, and many times, the medical staff must comply. These requirements, meant to enhance patient safety and increase public awareness of certain hospital acquired conditions frequently affect documentation and reimbursement. Significant legislation in recent years related to the public reporting of infections has occurred. St Joseph Hospital Infection Prevention Staff, in order to comply with California Health and Safety Codes as well as Centers for Medicare and Medicaid (CMS) requirements submit the following data to NHSN (CDC) for public reporting: surgical site infection data, central line associated bloodstream infections, urinary catheter associated urinary tract infections, MRSA and VRE bloodstream infections (both community onset and healthcare associated –HAI), Clostridium difficile infections (both community onset and HAI), central line insertion practices.

Medical Staff Screening for Tuberculosis and Other Communicable Diseases:

The requirements are based on the Centers for Disease Control (CDC) “Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Healthcare Settings 2005,” and the Joint Commission Hospital Accreditation Standards 2008, (IC.2.10 & IC.4.10) and include:

Tuberculosis Screening – Required for initial appointment and required annually:
1. TB screening must be done ANNUALLY. The number of active TB cases treated at St. Joseph Hospital places the hospital into an intermediate risk category which necessitates screening every year.
2. Annual screening methods depend on the skin test status of the individual, specifically:
   • Medical Staff members with a history of a positive tuberculin skin test (treated or not) OR who have been treated for active tuberculosis will be required to obtain a baseline chest-x-ray on initial appointment AND then ANNUALLY complete a symptom review form. No follow-up chest x-ray will be required every year unless the symptoms are positive.
   • Medical Staff members with a negative tuberculin skin test will ANNUALLY obtain a tuberculin skin test AND complete a symptom review form.
Other Communicable Disease Screening – Required for Initial appointment only:
1. Hepatitis B Vaccination History (vaccination strongly recommended)
2. Rubella Vaccination History
3. Rubeola Measles Vaccination History
4. Mumps Vaccination History
5. Varicella Vaccination History
6. Tetanus/Pertussis Vaccination History

Based on the completion of the Confidential Communicable Disease Screening form, Employee Health Services will be making recommendations for immunizations available at no charge through the Employee Health Services office.

You may obtain TB skin test screening through your own health provider but must provide documentation that includes the millimeters of induration recorded and any erythema. A reading stating merely “negative” or “positive” is inadequate documentation. Symptom review must be completed on the St Joseph Hospital form. Self-administration and reading of TB skin tests is not acceptable documentation.

All documents are required to be reviewed by the Employee Health Services department (documents may be faxed) and at which time an e-mail will be sent to the Medical Staff office validating compliance to the requirements. Medical information will be maintained in confidence by the Employee Health Services department.

TB skin testing may also be obtained through St. Joseph Hospital Employee Health Services office located in the basement of the Sister Francis Dunn Building, Monday-Friday between the hours of 7:30am-3:30pm. Employee Health Services can be reached directly at (714)-771-8055 and the fax number is (714)-744-8667
MULTI-DRUG RESISTANT ORGANISMS AND ACTIVE SURVEILLANCE

*Methicillin-Resistant Staphylococcus Aureus* (MRSA) is now endemic in many U.S. hospitals and investigators for the Centers for Disease Control Prevention (CDC) have noted substantial increases in both community and healthcare-associated infections. Driven by the emerging concern that community-associated MRSA (CA-MRSA) has entered the hospital environment, the medical community and the public are seeking to limit the spread of this organism with increasing urgency. Guidelines from the CDC regarding methods to control the spread of multidrug-resistant organisms (MDRO), such as MRSA, include hand hygiene, contact precautions, AND expanded surveillance of asymptomatic patients in settings in which multidrug-resistant organisms are increasing or not responding to other interventions. The use of active surveillance and rapid implementation of Contact Precautions has significantly reduced MRSA infections in some hospitals, most notably at Evanston Northwestern Healthcare in Illinois.

On January 1, 2009, California Senate Bill 1058, Chapter 296, Statutes of 2008 and Senate Bill 158, Chapter 294, Statutes of 2008 became effective. The statutes require general acute care hospitals to implement specified procedures and processes designed to reduce the incidence of healthcare-associated infections (HAI). Specifically, beginning January 1, 2009, general acute care hospitals must begin testing patients for MRSA within 24 hours of admission to the hospital.

In response to the new regulations, St Joseph Hospital has instituted an MRSA Active Surveillance Screening program. Active surveillance is the practice of routinely culturing patients upon hospital admission to determine if they are an unrecognized carrier of MRSA. Early identification of colonized patients will be a first step in preventing colonization of other patients and staff as well as provide valuable information to the attending physician who may choose to institute decolonization, on a case by case basis, in order to reduce the patient’s subsequent risk of later infection.

MRSA Active Surveillance Screening is performed by the Nursing Staff under the direction of a Standardized Procedure. Screening is performed on all inpatient admissions, upon transfer to or admission to the Critical Care Units, weekly in Critical Care, and upon discharge.

**CA Senate Bill 1058 requires if a patient tests positive for MRSA, the attending physician shall inform the patient or the patient’s representative immediately or as soon as practically possible.** Prior to discharge, hospital staff must provide oral and written instruction to the patient regarding aftercare and precautions to prevent the spread of the infection to others.

Should you have any questions on this program, do not hesitate to contact the Infection Prevention and Control Department at 714-771-8105 or extension 18105.
HAND HYGIENE

Hand Hygiene is the single most important means of preventing the spread of infection. When properly practiced, it can reduce hospital-associated infections by as much as 90%. The rationale for hand washing includes reducing the risk of transmission of microorganisms to patients, reducing the potential for colonization or infection of healthcare workers with patient’s microorganisms and decreasing the morbidity, mortality and costs associated with healthcare-associated infections.

Indications for hand hygiene include, yet are not limited to: before medication or food preparation, before a procedure or any other direct patient care, after contact with patients’ intact skin (e.g. taking a pulse or BP, performing physical exam, moving a patient in bed), after contact with environmental surfaces in the immediate vicinity of patients, and after glove removal.

The latest CDC Hand Hygiene Guidelines recommend that healthcare workers (HCW) use alcohol-based hand rubs (gel, rinse or foam) to routinely clean their hands between patient contacts UNLESS the hands are visibly soiled or the patient has diarrheal illness, particularly Clostridium difficile (aka C. diff) and Norovirus. In these instances, water and antimicrobial soap must be used.

Hand washing with water should be conducted for a minimum of 15 seconds using hospital approved soap, running water and friction ensuring that all hand surfaces, between fingers and under nails, are included.

PREVENTING SURGICAL SITE INFECTIONS (SSI)

It is the policy of St. Joseph Hospital to implement practices consistent with evidence-based standards of care to reduce the risk of SSI’s. It is an organization-wide program and it applies to all care settings that perform operative procedures & surgeries.

Preparation of the Patient:

Whenever possible, infections remote to the surgical site should be identified and treated before elective procedures. Elective procedures should be postponed – if necessary – until the remote infection has resolved.

The CDC recommends educating patients to shower or bathe with an antiseptic agent on at least the night before the operative day.

Hair should not be removed preoperatively unless the hair at or around the incision site will interfere with the operation. If hair must be removed, it should occur immediately before the operation with electric clippers. Shaving with a razor blade is not an appropriate method for hair removal.
The area around the intended incision site should be thoroughly washed and cleaned to remove gross contamination before and in addition to performing antiseptic skin preparation. Alcohol-based, Chlorhexidine-based, and iodine-based antiseptics are acceptable for use. When an antiseptic agent is applied, the prepared area must be large enough to extend the incision or create new incisions or drain sites, if necessary.

**Administration of Prophylactic Antimicrobial Therapy:**

Prophylactic antimicrobial agents should be administered only when indicated and selected based on their efficacy against the most common pathogens causing SSI for a specific operation and published recommendations. If an antimicrobial agent for prophylaxis is used for a particular surgical procedure or disease, it shall be administered as follows:

- Intravenous antimicrobial prophylaxis shall be administered within one hour before incision (two hours are allowed for the administration of vancomycin and fluoroquinolones).
- The routine use of vancomycin for antimicrobial prophylaxis is not recommended.
- Prophylactic antimicrobial agents should be discontinued within 24 hours after surgery (within 48 hours is allowable for cardiothoracic procedures).
- See the General Guidelines for Antimicrobial Selection in Surgical Prophylaxis if antibiotics are indicated. (Quality Outcomes Management Section).

**Antisepsis for Operative Personnel:**

Fingernails must not exceed ¼ inch beyond the fingertip. Cuticles, hands and forearms must be free of jewelry, open lesions &/or breaks in skin integrity. Fingernail polish must be free of chips and cracks. Artificial nails, defined as substances or devices applied to the natural nail to augment or enhance the nail, including but not limited to; tips, wrappings, and tapes, cannot be worn by any personnel with direct patient contact.

Personnel must practice general hand hygiene immediately before and after patient contact.

An anatomical scrub method that uses a prescribed number of strokes or specified amount of time for scrubbing each surface of the fingers, hands and arms or an alcohol-based surgical hand-rub product with persistent activity may be utilized for surgical hand antisepsis.

Surgical hand antisepsis will be performed before donning sterile gloves for surgical or other invasive procedures. The surgical hand antisepsis agent should significantly reduce microorganisms on intact skin, contain a non-irritating antimicrobial preparation, be broad spectrum and be fast acting and have a residual effect.
Cleaning & Disinfection of Environmental Surfaces:

An Environmental Protection Agency (EPA)-approved hospital disinfectant must be used to clean the affected areas before the next procedure, and when visible soiling or contamination with blood or other body fluids of surfaces or equipment occurs. Manufacturer instructions relative to wet contact time and drying times of the disinfectant shall be followed.

Sterilization of Instrumentation:

All surgical instruments shall be sterilized in accordance with published guidelines and standard of care. Flash sterilization should be performed only for patient care items that will be used immediately.

Surgical Attire and Drapes:

A surgical mask that fully covers the mouth and nose must be worn when entering the operating room if an operation is about to begin or already under way, or if sterile instruments are exposed. The mask is to be worn throughout the operation. A cap or hood to fully cover hair on the head and face must be worn when entering the operating room. Sterile gloves must be worn by all scrubbed surgical team members. Surgical gowns and drapes that are resistant to fluid penetration should be used. Surgical scrub clothing that is visibly soiled, contaminated, and/or penetrated by blood or other potentially infectious materials must be changed out.

Asepsis and Surgical Technique:

Principles of asepsis should be adhered to when placing intravascular devices (e.g., central venous catheters), spinal or epidural anesthesia catheters, or when dispensing and administering intravenous drugs. Tissue should be handled gently and effective hemostasis maintained.

Postoperative Incision Care:

For an incision that has been closed primarily, the site should be protected with topical skin adhesive or a sterile dressing per the Surgeon’s direction and orders. When a dressing must be changed, sterile technique must be used. Staff must follow appropriate hand hygiene practices.
PREVENTING CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS (CLABSIs)

It is the policy of St. Joseph Hospital to implement practices consistent with evidence-based standards of care to reduce the risk of central line-associated bloodstream infections. These practices include, but are not necessarily limited to, the following:

Equipment & Supplies:

The organization has assured that equipment and supplies are available when a central line is inserted. At a minimum this includes:
- Central venous catheter
- Central venous catheter insertion kit
- Sterile drapes
- Barrier protection, see #3 below
- Chlorhexidine-based antiseptic skin preparation (not required for patients < 2 months of age)
- Local anesthetic
- Line maintenance anticoagulant appropriate to the line type and patient age / presentation
- Site dressing

Central Venous Catheter Insertion:

Whenever a central venous catheter is inserted, the following shall occur:

1. If possible, the procedure should be explained to the patient and family. Appropriate consent should be obtained for non-emergent need.
2. Hand hygiene must be performed by all staff involved in the procedure prior to catheter insertion.
3. Maximum barrier precautions shall be deployed, including hair cover, masking, and sterile gowning and gloving of all personnel involved in the procedure, as well as sterile prepping and draping of the insertion site, including full body drape over the patient.
4. If body hair needs to be removed, it should be clipped rather than shaved.
5. A chlorhexidine gluconate-based antiseptic skin preparation shall be used on all patients over 2 months of age unless contraindicated. For all other patients, the physician shall determine the appropriate antiseptic skin preparation.
6. Catheters should not be inserted into the femoral vein unless other sites are not available.
7. Catheters should be secured in place and a sterile occlusive dressing applied following insertion.
8. Confirmation of proper placement (e.g. x-ray or other test) should be performed.
Accessing Central Venous Catheters:

To reduce the risk of infection, accessing central venous catheters should be limited to necessary use. Catheter valves, hubs and injection ports must be appropriately disinfected prior to every access (“scrub the hub”).

Dressing Changes: Dressing changes are to occur as required by policy.

Documentation of Continued Need for Central lines and Removal of Central Venous Catheters:

Catheters should be evaluated routinely and removed as soon as the patient’s clinical status and needs will allow. Non-essential catheters should be removed. The necessity of the central line must be documented DAILY by the physician (CA Senate Bill 739).

PREVENTING CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)

- Patients should meet policy inclusion criteria for indwelling urinary catheters and should have the urinary catheter removed as soon as possible and/or as soon as the clinical situation resolves.
- Inclusion criteria for indwelling urinary catheters: strict intake and output when patient is unable to cooperate with bathroom, bedpan or urinal use, documented urinary retention or obstruction, perioperative/postoperative for gynecologic, peri-rectal or urological procedures or procedures/diagnostics greater than 2 hours, incontinent patients with stage 3-4 coccyx or sacrum pressure ulcers, comfort measures in a terminal patient or if turning is too uncomfortable, displaced pelvic fractures, spinal anesthesia and patients with epidural catheters.
- Exclusion criteria for indwelling urinary catheter: incontinence, diarrhea, diuretics and patients undergoing any invasive procedure <2 hours in length.
- To enhance efforts to prevent CAUTI, a standardized procedure to allow nursing staff to remove Foley catheters (Nurse-Driven Indwelling Urinary Catheter (IUC) Removal Algorithm) has been adopted by St Joseph Hospital. Following RN assessment that a patient no longer meets inclusion criteria for continued IUC the RN may discontinue the IUC without a physician order. A physician order to “continue indwelling urinary catheter/Foley and do not discontinue catheter without physician order” shall be followed, and the RN-driven Foley removal protocol will not apply.
PREVENTING THE TRANSMISSION OF HOSPITAL ASSOCIATED INFECTIONS (HAI) INCLUDING MULTI-DRUG-RESISTANT ORGANISMS (MRSA, VRE and ESBL) and CLOSTRIDIUM DIFFICILE (C. diff)

As required by California Senate Bills 158, and 1058 and The Joint Commission National Patient Safety Goals, all employees, including independent practitioners, are required to be trained to prevent the transmission of HAI including MDRO and C. diff.

St. Joseph Hospital performs periodic assessments to identify the risk of acquisition and transmission of MDRO. Based on this assessment, the organization has identified the following MDRO’s to be of epidemiologic significance:

- MRSA (Methicillin Resistant Staphylococcus Aureus)
- VRE (Vancomycin-Resistant Enterococci)
- C. diff (Clostridium difficile)
- Extended Spectrum Beta-Lactamase (ESBL) producing bacteria
- Carbapenem-Resistant Enterobacteriaceae (CRE)
- Multi-Drug Resistant Pseudomonas and Acinetobacter

To effectively reduce the risk of transmitting or acquiring an infection from these organisms, the following measures are utilized:

**Hand Hygiene:**

Staff and physicians must adhere to appropriate CDC recommendations on hand hygiene consistent with organization policy in this area. This has previously been reviewed at the beginning of the Infection Prevention & Control section of this education packet.

**Patient Placement:**

Patients who are infected or colonized with infectious organisms should be placed in a private room. When a private room is not available, patients with an MDRO may, with coordination with Infection Prevention staff, be cohorted. Cohorting is the practice of grouping together patients who are colonized or infected with the same organism to confine their care to one area and prevent contact with other patients. All efforts to avoid cohorting should be made.

**Standard Precautions:**

Standard Precautions require healthcare workers (and others) whose activities involve contact with patients or with blood and body substances to:

- Observe a single level of precautions for all patients at all times regardless of their known disease status.
- Routinely use appropriate protective barriers and procedural precautions to prevent
needle-stick, mucous membrane, and non-intact skin exposure to blood and body substances.

- Wear gloves when touching blood, body substances, mucous membranes, or non-intact skin of patients, when performing procedures that require contact with blood or body substances, and when handling items soiled with blood or body substances.
- Wear face protection (masks and protective eyewear) and fluid-resistant gowns during procedures that are likely to generate droplets or splashes of blood or body substances.
- Cleanse hands between patient contacts, after removing gloves, and when soiled with blood or body substances.
- Use extreme care when handling needles, scalpels, and other sharp instruments. Do not recap needles. Dispose of sharp instruments into puncture-resistant containers at point-of-use. Failure to properly dispose contaminated needles and sharps is a serious breach of Infection Control policies. The Bloodborne Pathogen Control Plan is required by the California Occupational Safety and Health Administration (Cal/OSHA) to protect all individuals from exposure to bloodborne pathogens and is available on the St. Joseph staffhub (under Policies & Forms tab) or in the Infection Control Department.
- Healthcare workers with exudative lesions or weeping dermatitis should refrain from all direct patient care activities and contact with blood or body substances.

Transmission-Based Precautions (aka Isolation Precautions):

The purpose of Transmission Based Precautions is to provide a framework to hospital staff for the care of patients with known or suspected communicable diseases, or patients who are colonized with epidemiologically significant organisms, for which additional precautions beyond standard precautions are needed to interrupt transmission.

These precautions represent a collection of prudent practices which are based either on well-documented modes of transmission identified in epidemiologic studies or on consensus recommendations published by experts in the field. There are four types of transmission based precautions; Airborne, Droplet, Contact Precautions and Contact Precautions Spore Precautions.

Patients with MDRO (both colonized and infected including MRSA nasal colonization) shall be placed on Contact Precautions (isolation). Patients with MDRO positive cultures should remain in appropriate isolation precautions for the duration of their present admission and any future admissions to the hospital.

Once no longer considered infectious, patients may be removed from isolation with the approval of the treating physician or Infection Prevention and Control professional.

Use of Personal Protective Equipment (PPE):

Gloves and gowns must be worn when caring for patients with MDRO. Consult appropriate Infection Control policy if you have any questions.
Information on personal protective equipment type, proper use, location, removal, handling, decontamination, and disposal can be found in the Infection Control Manual under the tab entitled “Isolation Practices” or located on staffhub under the Policies and Forms tab.

**Use of Antibiotics:**

The selection and ordering of antibiotics may be restricted as determined by the organization and Medical Staff. Adherence to these restrictions is expected.

**Patient Transport:**

For patients in Contact Precautions, as much as possible, necessary treatments and procedures should be performed at the patient’s bedside. If essential tests must be performed in another area, the receiving department must be notified that the patient has an MDRO prior to transporting the patient to that department.

**General procedures for personal protection**

- Become familiar with the Infection Control Manual as it relates to your job tasks.
- Do not eat, drink, smoke tobacco, chew tobacco, dip tobacco, or apply cosmetics or contact lenses in your work area. Always wash your hands before doing these things.
- Store all food in “Food Only” refrigerators.
- Cover/cap prepared foods and drinks when transporting out of cafeteria or vending machines to eating locations.
- Wear protective barriers when it is indicated, and observe infection control and safety procedures consistently.
- Healthcare workers should practice droplet precautions when indicated, (i.e. wear a mask for close contact with patients exhibiting signs of respiratory infection). At times of increased or novel influenza activity, precaution levels may be increased in accordance with state or federal guidelines.
- Services are available through Employee Health (ext. 18055) for baseline titer testing for Rubella, Rubeola, Varicella and Hepatitis B. If an exposure occurs, post exposure management including assessment, information and referral is also available.

Information on personal protective equipment type, proper use, location, removal, handling, decontamination, and disposal can be found in the Infection Control Manual under the tab entitled “Isolation Practices” or located on staffhub under the Policies and Forms tab.
RESPIRATORY (AEROSOL TRANSMISSIBLE DISEASE) AND RASH ILLNESS

The Aerosol Transmissible Disease Control (ATD) Plan is required by Cal/OSHA to protect all individuals from exposure to TB or other airborne transmissible diseases/pathogens and is available on the St. Joseph staffhub or in the Infection Control Department.

Effective September 1, 2010 the ATD Standard (defined by the California Occupational Safety & Health Standards Board) requires employers to provide to employees a Powered Air Purifying Respirator (PAPR) with a High Efficiency Particulate Air (HEPA) filter for all high-hazard aerosol generating procedures as defined by Cal OSHA and the CDC. The PAPR’s are to be available for use during procedures performed on patients with known or suspected “Airborne Infectious Disease/Pathogens” unless determined that this use would interfere with the successful performance of a required procedure or task.

A PAPR uses its own power source and a HEPA filter to provide the wearer with his or her own filtered air supply. Because a HEPA filter is as efficient as a P-100 filter-and because PAPRs have less face-seal leakage—a PAPR provides a higher level of respiratory protection than a filtering face piece or a half-mask elastomeric respirator. Additional benefits of PAPRs include: eliminates fit testing, increases protection from aerosolized and contact contaminants, optimizes splash protection, facial hair and eyeglass friendly features and is cost effective.

The following are “Airborne Infectious Diseases/Pathogens” identified by Cal/OSHA in the ATD Standard that currently require the use of a negative airflow room and N95 Respirators (PAPR required after September 1, 2010 for all persons present when performing a high hazard procedure).

- Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/Bacillus anthracis
- Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
- Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
- Measles (rubeola)/Measles virus
- Monkeypox/Monkeypox virus
- Novel or unknown pathogens
- Severe Acute Respiratory Syndrome (SARS)/SARS-Associated Coronavirus (SARS-CoV)
- Smallpox (variola)/Variola virus (see vaccinia for management of vaccinated persons)
- Tuberculosis (TB)/Mycobacterium tuberculosis – Extrapulmonary, draining lesion; suspected or confirmed pulmonary or laryngeal disease

The emergence of new pathogens and the resurgence of old pathogens (e.g. SARS, seasonal influenza, H1N1 Influenza, Avian Influenza, Tuberculosis, Measles and Pertussis) require that we maintain a high index of suspicion when patients present with undiagnosed respiratory or rash illnesses.
Patients with fever or cough or a rash should practice cough etiquette. Specifically, wait in a separate area, if possible, at least 6 feet away from other persons, be given a mask, be instructed to COVER their cough with a tissue if mask is not available and use proper hand hygiene.

Tuberculosis is still prevalent in foreign countries such as Central and South America, Asia and Eastern Europe. In 2013, Orange County ranked eleventh in the State based on TB case rates and had the third highest number of TB cases in California behind Los Angeles and San Diego Counties. Orange County’s 2013 rate of 6.0 cases per 100,000 remained higher than the national Healthy People 2020 objective of one (1) TB case per 100,000 population. 'Tuberculosis Fact Sheet, County of Orange Healthcare Agency Pulmonary Disease Services, 2013. http://ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=13511

In 2013 (the last year of available reported data), Orange County TB cases were more likely to be Asian, foreign-born and 65 years and older. Of the 187 cases reported in Orange County in 2013, 91.4% were among persons born outside the United States. The top five countries of origin of foreign-born persons with TB were Vietnam (38.0%), Philippines (19.9%), Mexico (15.8%), Korea (6.4%), and China (4.1%).

In 2013, five Orange County cities with the highest TB case rate were: Westminster (19.7 per 100,000 of population), Garden grove (17.9), Tustin (7.7), and Santa Ana and Lake Forest (7.6 per 100,000). Several of these cities are in the St. Joseph Hospital service area. These case rates are higher than Orange County overall (6.0), California (5.7) and the US (3.0). If a patient has symptoms such as fever, hemoptysis, persistent cough, night sweats, unexplained weight loss, immunocompromised diseases, or a history of treatment for TB, precautions should be taken until active, pulmonary TB is ruled out. In these instances, take the following actions to promote patient and staff safety:

- Airborne Precautions in a Negative Airflow Room
- Use N-95 mask
- Promptly obtain diagnostic tests which include sputum for Acid fast bacilli (AFB) x 3, chest x-ray, TB skin test
- Place a surgical mask on the patient if transported out of the negative airflow room

Global Community and Emerging Diseases

People are traveling more. Food and medical product supply chains stretch across the globe. Biological threats [such as Ebola and MERS-CoV (Middle East respiratory syndrome coronavirus)] and drug-resistant illnesses pose a growing danger to people everywhere, whether diseases are naturally occurring, intentionally produced, or the result of a laboratory accident. In today’s interconnected world, poorly treated cases of tuberculosis, measles or pneumonia in Asia and Africa have shown up in U.S hospitals within days. Cooperation with the state and local health departments and the CDC as
well as education of the St. Joseph Hospital staff and medical staff, are a priority in the Infection Prevention Department. All healthcare professionals should maintain a high index of suspicion for emerging pathogens and diseases.

**AIR HANDLING SYSTEM**

The air handling system can be set to minimize airborne contamination from one area of the hospital to another.

- Certain patients with highly infectious diseases that are spread by the airborne route require negative air pressure. The air flows into the room.  
  *Example:* Tuberculosis patient in isolation.

- Certain patients who are severely immunocompromised require positive air pressure. The air flows out of the room.  
  *Example:* Bone marrow transplant patient.

**BIOHAZARDOUS MATERIALS MANAGEMENT**

- Signs displaying the International Biohazard Symbol and the word BIOHAZARD are used to warn of the presence of biohazardous materials, including bio hazardous waste.
- Biohazardous waste is collected in specially marked red bags or puncture-resistant red buckets.
- Biohazardous waste is either steamed or burned in compliance with Department of Health regulations.
- Biohazardous Spills require special precautions for cleaning and disposal (consult the Environment of Care Manual, located on staffhub).

**INFECTION CONTROL DURING CONSTRUCTION AND RENOVATION**

Construction, demolition, and remodeling activities in or around the hospital may cause disturbance of existing dust, or create new dust. In addition, construction activities may interrupt or disturb plumbing and water systems. Protective measures and infection control protocols are followed during construction activities inside or outside of the hospital.
USE OF RESTRAINT OR SECLUSION

Restraint and Seclusion regulations require that physicians authorized to order restraints or seclusion have a working knowledge of hospital policy regarding the use of restraints and seclusion. Please find the complete policy located on staffhub. Key portions of the policy are listed below.

Physical Restraint:
Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition

Safety/Non-Violent/Non-Self Destructive Behavior:
It is a restraint used to limit mobility or temporarily immobilize a patient for non-behavioral management reasons.

Violent or Self Destructive Behavioral Restraint:
It is a restraint used to limit mobility or temporarily immobilize a patient who presents with behavior management symptoms
Symptoms that represent an imminent physical danger to self or others include assault, physically violent acting out, extreme agitation, self-mutilation, and active suicide attempt

1. Requirements for orders for all forms of restraints or seclusion. These requirements apply to orders for physical restraints or seclusion.
   • Only a physician may order restraints or seclusion.
   • Standing and PRN orders are NOT acceptable.
   • The least restrictive form of restraints must be ordered.

2. Requirements for Orders for Safety/Non-Violent/Non-Self Destructive Behavior:
   • A physician must be contacted immediately to issue a verbal or written order covering the emergency use of restraint. This must take place within minutes and if unable to reach the physician within 1 hour the RN should activate the chain-of-command
   • An order continuing restraints must be obtained no less often than once each calendar day and must be based upon an examination of the patient by the physician
• Staff may not discontinue a restraint or seclusion intervention, and then re-start it under the same order, this would constitute a “trial release” which is not permitted

Policy Statement and Patient Rights:

Each patient has a right to respectful care that maintains his or her dignity. Restraints are utilized only as a therapeutic or safety measure to prevent harm to the patient or others. Assessment for appropriate use and application of restraints will be completed by staff validated as competent. Restraints are never used as a form of punishment, discipline or for staff convenience. Least restrictive/alternative measures are always considered prior to the initiation of use of any restrictive device or seclusion. Please refer to policy: PC-277 Restraints and Seclusion, located on staffhub.

PAIN MANAGEMENT

St Joseph Hospital believes in the intrinsic dignity of every person. Every person has the right to receive and participate in the decision regarding the treatment and management of their pain. Pain is assessed by physicians, nurses, and other health care professionals providing direct patient care. Assessment of pain should be communicated using verbal report and written documentation. The health care team will promptly address communication of unrelieved pain by patients/family/staff (Pain Management Reference: RI-035, located on staffhub).

Patient Refusal of Pain Management:
Appropriate assessment and management of the patients pain, information about pain, pain relief measures and to participate in pain management decisions. The patient may request or reject the use of any or all modalities to relieve pain, including opiate medication, if they suffer from severe chronic intractable pain. The doctor may refuse to prescribe opiate medication, but if so, must inform the patient that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiate (Patient Rights and Responsibilities Reference: RI-006, located on staffhub).
PHYSICIAN IMPAIRMENT

The purpose of the St Joseph Hospital Committee on Physician Health is to support the well-being of our physicians, in so doing, to protect patient welfare, improve patient care, and improve Medical Staff functioning. The Committee works to achieve this purpose through facilitation of, treatment for, prevention of, and intervention in alcohol-related, drug related, and behavioral problems of members of the Medical Staff. The Committee aims to foster a culture of mutual concern, safety, professionalism, and confidentiality.

For more information on physician impairment, please refer to the Medical Staff bylaws.

MEDICATION SAFETY

St. Joseph Hospital promotes a Culture of Safety. We encourage all health care practitioners to report all patient care and medication events that reach the patient as well as those that do not, through our online incident reporting system. The majority of medication events are due to system issues and it is inappropriate to place blame on individuals. As a physician, you are encouraged to report events directly into the system or to ask other healthcare staff to assist you in the process. When patient care events and patient safety issues are reported and documented this allows the hospital to involve the healthcare team to take action to fix the system and prevent further risk to our patients.

When entering orders into the computer system or writing orders in those areas which do not have CPOE, do your part to prevent some common patient safety problems:

- When interaction and alert flags pop up review them before overriding them
- Use order sets whenever possible
- For special instructions on medication orders type the instructions AT THE TOP of the “Dose Instruction” or “Comments” fields so that nursing and pharmacy can see them and ensure that they are followed.
- Review medication first dose pop-ups as they assist you in choosing when to start medication therapy.
- For questions on how to use the system call the Physician Liaisons at 17996
- For medications you may order often and wish to add to your favorites list call the Physician Liaisons at 17996 to help you set this up
- Report issues/Mistakes/Errors to the Physician Liaisons at 17996. You can also request that an e-ticket be created to fix the issue
- Review the list of home meds and select only critical meds that need to be continued in the hospital. Do not choose to continue ALL medications without reviewing.
- Duplicate therapy – avoid ambiguous and potentially hazardous duplicate orders, particularly in pain medication therapy by clearly specifying which agent is to be used when. For example, for mild pain, for moderate pain, for severe pain or if patient cannot tolerate orals
Labeling of medications & solutions:
• Label all medications, medication containers and other solutions on and off the sterile field in perioperative and other procedural settings.
• Labeling occurs when any medication or solution is transferred from the original packaging to another container.
• Label each medication or solution as soon as it is prepared, unless it is immediately administered.

Note: An immediately administered medication is one that is prepared and administered without any break in the process.

Dosing medications in the elderly:
The Medical Staff has approved of guidelines on dosing analgesics, antidepressants, antipsychotics and anxiolytic agents. Your clinical pharmacist will contact you if your dosing should exceed the guidelines for dosing in the elderly. You can access these dosing guidelines through the clinical applications & resource page under Medication Management Resources or through dosing information in Lexi-Comp. When dosing narcotics and benzodiazepines in the benzodiazepine-naïve and opiate-naïve elderly it is always recommended to start at a lower dose and repeat if necessary.

Anticoagulation Management Protocols for Warfarin, Heparin IV Infusion, Low Molecular Weight Heparin (LMWH):

1. INDICATIONS: Physicians must include the following required elements in the patient’s chart prior to initiation or continuation of therapy from home/other facility.
   • Warfarin: Indication & goal INR
   • Heparin IV infusion: Indication & goal aPTT
   • LMWH: Indication
   
   Note: physicians have an option to indicate “Goal INR or aPTT per protocol”.

2. LABORATORY MONITORING: Physicians must order baseline and routine laboratory monitoring as specified below prior to initiation or continuation of therapy from home/other facility. Baseline lab results prior to admission are acceptable if done within 4 weeks of admission. Abnormal baseline labs will be repeated at the time of therapy initiation or continuation in the hospital.

• Warfarin
  ➢ Baseline PT/INR
  ➢ PT/INR daily during titration phase
  ➢ PT/INR at least q 3 days in patients on a stable maintenance dose
  ➢ CBC at baseline and at least q 3 days

• Heparin IV infusion
  ➢ Baseline aPTT
  ➢ aPTT 6 hours after initiation of heparin therapy and after any change of heparin infusion rate until the goal aPTT is achieved.
  ➢ Once the goal aPTT has been achieved for 2 consecutive aPTT readings, continue heparin infusion at the current rate, and order a daily aPTT to be done with the patient’s morning laboratory studies
  ➢ CBC at baseline and at least q 3 days
• LMWH
  ➢ BMP at baseline and at least q 3 days (to measure renal function via creatinine clearance (CrCL) calculation to appropriately dose LMWH)
  ➢ CBC at baseline and at least q 3 days

3. DOsing: Physicians must use the medical staff approved dosing protocol for warfarin, heparin IV infusion, and LMWH. These are available on the clinical applications & resource page under Medication Management Resources and in Lexi-Comp.

Education of Patients and Families:
Patients and – as appropriate – families will be educated on anticoagulant therapy. This education shall include – but not necessarily be limited to – the following:
  • Importance of follow-up monitoring,
  • Compliance issues
  • Dietary restrictions
  • Potential for adverse drug reactions and interactions

Evaluation of the Anti-Coagulant Therapy Program:
The organization shall regularly evaluate safety practices associated with the management of patients placed on anticoagulation therapy. This evaluation may take the form of:
  • Analyzing medication errors and adverse drug reactions associated with the use of anticoagulation therapy
  • Monitoring adherence to protocol
  • Evaluating protocol effectiveness
  • Other measures as may be deemed appropriate
The hospital's Information Management Plan describes the process for maintaining documentation when there is either an interruption in power or information systems components. To view history, dictations/reports, and the EMR use the SoCal.L.EMR icon. If the SoCal.L.EMR link is also down, Physician Connect Web Portal can be utilized. The physician should log into https://sjo.physconnect.org using their own account, which gives them access to past patient information as of the time the system went down. If the physician does not have their own account, they should see the Charge Nurse for assistance. To view imaging studies the Downtime PACs should be viewed. During the downtime, the physician uses hospital approved paper order sets or blank order forms for orders, blank paper progress notes, and paper discharge instructions. In case of a network downtime, there is a "Downtime Computer" on each nursing unit that contains the following patient information reports:

1. Paper Medication Administration Record
2. Unit Census
3. ED Summary
4. Lab Summary
5. Diet Report
6. Pharmacy Profile

The unit secretary or designate will print all reports for the unit and deliver to each nurse. The Emergency Department will convert to the legacy system EMSTAT in conjunction with paper documentation, in case of a downtime.
INFORMATION SOPHISTICATION SUPPORTING PERFECT CARE

St. Joseph Health offers a variety of Information Technologies to support patient care delivery. We have also implemented further enhanced technologies such as online physician documentation and computerized provider order entry.

Listed below is an overview of the applications utilized by our physicians.

- **Meditech Health Information System** – Electronic Medical Records (EMR)
- **Meditech Mobile Rounding** – EMR access via smartphone or tablet.
- **HealthEPix** – Wound Imaging, classification/indexing, and documentation solution
- **Synapse PACS** – Radiology Picture Archiving Communication System
- **PerfectServe** – Communication Tool – PHI Secure communication solution via smartphone
- **Chartmaxx** – Electronic Health Record Document management system.
- **Physician Connect** – Web Portal used to view limited patient information and links to many resources. This is available via the Internet and to your office staff.
- **Dragon Medical** - Voice Recognition available on Easypass2 for Meditech documentation.
- **Citrix** – Allows remote access to network at cloud.stjoe.org
- **staffhub** - Designed to connect you in real-time to the content, people and apps you need to be successful anywhere, from any device.

### Department Specific Systems

- **PICIS** – Perioperative documentation system
- **Clinical Vision** – Renal Center documentation system
- **Centricity/OBLink** – Perinatal documentation system
- **Syngo PACS** – Cardiology Picture Archiving Communication System

### Online Decision Support Resources

- **Up to Date** – Evidence based research (available for your smart device)
- **MD Consult** – Comprehensive resource of information
- **Zynx** – Evidence based practice guidelines
- **Lexi-Comp** – St. Joseph’s Drug Formulary

The Medical Staff/Physician Support Team will assess your clinical information system needs and will provide and/or facilitate training of the appropriate systems. Once credentialing is complete you will receive communication to validate your login credentials with the physician support team. Please call x17996 for assistance and more information.
ASSIGNING PATIENT STATUS- PROCESS/CMS REGULATIONS

The following are key points regarding ordering correct patient status for hospital stay:

- CMS (Center for Medicare and Medicaid Services) 2014 IPPS Ruling effective October 2013 stipulated requirements for Inpatient Status. This applies only to FFS (Fee for Service) Medicare.

- Commercial Insurance, i.e. Blue Cross, Blue Shield, Medicare Advantage plans and Cal Optima plans do not fall under the recent CMS ruling and status is being determined by evidenced based criteria – SJO uses Milliman Guidelines. Admission status orders are also required for these payor’s.

- The 2 Midnight Benchmark under the 2014 CMS IPPS Ruling calls for the admitting physician to order Inpatient Status on Medicare FFS if the physician anticipates that a patient will require at least 2 midnights of medically necessary care in a hospital setting.

- If the patient has already been seen by MD in Emergency Care Center or been in Observation status for one midnight, Inpatient Status should be ordered if the patient will need at least one more medically necessary midnight in the hospital setting. The ED or Observation episode of care counts towards the Benchmark of 2 midnights in hospital setting but does not count towards 3 consecutive medically necessary midnight requirement for SNF.

- Medicare requires RN telephonic and PA/NP entered Patient Status orders to be co-signed by physician prior to discharge – or the order is considered invalid/unbillable.

- “Medical Necessity” is a requirement embedded in statute in all CMS regulations. Physicians assessing medical necessity should consider why the treatment needs to done in the hospital setting, and the physician’s documentation must reflect the reason for the decision that the patient requires hospital care.

Examples of Order Rationale:
“Pnuemonia: IV Abx and oxygen saturation monitoring”, “CVA:close neurological monitoring”

It is important for ED physician to collaborate with admitting physician to have the correct status on chart. ED physician and admitting physician must communicate and document why they think patient needs inpatient status.

Admitting physicians of evidence based criteria for Inpatient or Outpatient status. Patient Access RN can be reached on cell phone # (714) 446-7825. Case Management is also available to help determine correct patient status and can be reached at x 17111 or through the SJO Hospital
HOSPICE

St. Joseph Health, Hospice is owned by St. Joseph Hospital, St. Jude Medical Center (SJMC) and Mission Hospital. We are part of St. Joseph Home Health Network which includes Home Health, Infusion Pharmacy and Private Duty. We are Medicare certified and accredited by The Joint Commission. We have a full time liaison on site at the hospital 7 days a week to meet with patients and families. They can be reached through the Web Paging System on pager 1268. We are staffed to accept referrals from 8:00 am to 8:00 pm Monday through Friday.

St. Joseph Hospice provides comprehensive end-of-life care for patients who have a life expectancy of six months or less and have elected comfort care rather than aggressive treatment. We provided the following services to patients and families:

- Expert pain and symptom management
- Emotional and spiritual support to patient and their family
- Interdisciplinary Team: MD, RN, MSW, Chaplain, Hospice Aide, Volunteer, RD, Music & Massage Therapists, Bereavement Coordinators
- Medications, supplies, DME
- RN available by phone 24/7
- In home Comfort Pack for easy access to medications
- Comprehensive Bereavement for 1 year following the death

Hospice takes place in a patient’s home, extended care facility, SNF or at times in the hospital. St. Joseph Hospice has contracts with St. Joseph Hospital, SJMC and Mission to provide hospice services in the acute care setting under the Medicare Hospice General Inpatient (GIP) benefit. GIP is one of four levels of care under the Medicare Benefit. Some facts about GIP:

- Evaluated by and authorized by Hospice Team
- Short term for pain and symptom management
- Patient actively dying without symptoms does not meet criteria for GIP
- Evaluated every 24 hours. Once the patient is stable and the Hospice Team is no longer making changes to the Plan of Care, the patient must be discharge to lower level of care at home, extended care facility or SNF.
**PHYSICIAN QUICK REFERENCE**

The following are guidelines for evidence based care. Any time there are deviations from the guidelines document the reason(s) for that deviation.

**Medication Reconciliation for all Patients**
- Completed upon admission, post-operatively, when a patient transfers level of care, and upon discharge for all patients.
- DC Med Rec: Don’t forget to look at both home meds and meds ordered while in the hospital

**VTE prophylaxis for all Patients**
- Determine patient’s VTE risk, then place orders based upon your assessment. The assessment is not an order.
- Comfort Measures is for end of life patients with Comfort Measures only as an order
- Use the standardized VTE prophylaxis assessment and orders
  - Low risk patients: early and persistent ambulation
  - Moderate risk patients: Compression devices or anticoagulation or physician documentation of contraindications to whichever not ordered
  - High risk patients: Compression devices and anticoagulation or physician documentation of contraindications to both

**Indwelling Urinary Catheter**
- Use standardized order sets and nursing driven indwelling urinary catheter protocol
- Comfort Measures is for end of life patients with Comfort Measures only as an order

**Central Lines**
- Document the necessity for central lines every day. Central lines include non-tunneled, tunneled, implanted port (arm or chest), and PICC. The following are the only acceptable reasons to keep a central line in place:
  - Venous access problem
  - Hemodynamic monitoring/stabilization
  - Hyper-alimentation
  - Hemodialysis
  - Chemotherapy, oncologic
  - Phlebitis prone medication
  - Repeated administration of blood/blood products

**End of Life**
- Clearly document all co-morbidities (the goal is for the record to clearly portray how sick the patient was)
- Clearly document any “Courageous Conversations” where you discussed a prognosis with the patient / family, especially if it leads to code status changes
- Comfort Measures Only is an order. Comfort Measures Only is not curative treatment and includes only medical interventions to relieve pain and suffering through the use of medication by any route, positioning, wound care, and other measures.
- Hospice GIP patients are excluded from Mortality calculations. Hospice GIP is a higher level of Hospice care, sometimes referred to as the ICU of Hospice. GIP Hospice is to treat crisis exacerbation of symptoms for Hospice patients not actively dying.
- Hospice is a concept of care, not a specific place of care. Hospice emphasizes symptom relief rather than curative treatment and quality of life rather than quantity of life. Both patient and family are included in the plan of care that includes individualized physical, emotional, and spiritual care based upon the patient and family desires. Hospice affirms life and regards dying as part of the normal process of life. It does not hasten death and does not postpone death. Hospice is for patients with a limited life expectancy, usually six months.

**Heart Failure**
- Use standardized order set
- **LV assessment**
  - Test performed this admission or
  - Documentation of known EF from prior study/admission or
  - Documentation of a plan for LV assessment after discharge
- **ACE I or ARB on discharge** for LVEF <40% or documentation of contraindications to both

**Pneumonia**
- Use standardized order sets to ensure appropriate antibiotic selection
- Document type of pneumonia
- Document sources of infection other than respiratory
- Document compromise if it exists
  - HIV, HIV positive, AIDS, Immunodeficiency syndromes, chronic lymphocytic leukemia, organ transplants, ARC, etc.
  - Chronic steroids and/or systemic immunosuppressant therapy
  - Compromising therapies within the last 3 months
    - Systemic chemotherapy/radiation therapy
    - Systemic corticosteroid/predisone therapy
    - Systemic immunosuppressive therapy
- Document pseudomonas risk
  - Bronchiectasis
  - Structural lung disease and documented history of repeated antibiotics or long term/chronic systemic corticosteroid use within the last 3 months

**All Strokes and TIsAs**
- Use the appropriate Stroke Standardized Order Set
- Order rehabilitation services assessment prior to discharge

**Acute Ischemic Stroke**
- Use the appropriate Stroke Standardized Order Set
- Antithrombotic medication by end of hospital day 2 or documentation of contraindication
- Lipid panel within 48 hours after hospital arrival
- Anticoagulation therapy at discharge for patients with history of atrial fibrillation/flutter or history of paroxysmal atrial fibrillation or documentation of contraindication.
• If the patient had an ablation in the past, please document this as a contraindication to anticoagulation therapy at discharge.
• Antithrombotic medication on discharge or documentation of contraindication
• Statin on discharge or documentation of contraindication

AMI
• Use standardized order set
• r/o MI will be coded as AMI unless there is clear documentation stating the patient did not experience an AMI
• If you are the attending, you “own” the patient; do not depend on the cardiologist for documentation
• ASA administration within 24 hours after hospital arrival regardless of time of diagnosis and on discharge
  • Order first dose now
  • If patient rules in for AMI after the 24 hour window, document the reason why ASA not administered during the first 24 hours of the patient’s stay.
    ▪ (Usual reason is, “No ASA within first 24 hours related to no evidence of cardiac ischemia at that time.”)
• Beta Blocker at discharge or documentation of contraindication
• ACE I/ARB at discharge
  • If the patient has an EF <40%, they must be discharged on an ACE I or ARB or documentation of contraindication to both
• Statin on discharge or documentation of contraindication

PRBCs
• If you have ordered blood products in the last 12 months, favorites have been provided for you in CPOE.

<table>
<thead>
<tr>
<th>Indication</th>
<th>Hgb</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (elective)</td>
<td>&lt; 7.0</td>
<td>Transfuse 1 unit at a time.</td>
</tr>
<tr>
<td>ACS (elective) (Chest Pain / Angina, STEMI)</td>
<td>&lt; 8.0</td>
<td>Transfuse 1 unit at a time.</td>
</tr>
<tr>
<td>Hemorrhagic Shock</td>
<td>Variable</td>
<td></td>
</tr>
<tr>
<td>Unstable with hypotension</td>
<td>Variable</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Variable</td>
<td>Document indication and transfuse 1 unit at a time (if elective)</td>
</tr>
</tbody>
</table>

PATIENT SAFETY PROGRAM AND PLAN

St. Joseph Hospital Patient Safety Program and Plan is an organization-wide program which embraces the mission and vision of “Perfect Care” and applies to all members of the medical staff and hospital employees seven (7) days a week, twenty-four (24) hours a day. The plan encompasses all persons receiving care at St. Joseph Hospital, including in-patient, out-patient and ambulatory care locations.

St. Joseph Hospital acknowledges that every patient has the right to a safe environment, and an error-free care experience, and we are committed to undertaking a proactive approach to the identification
and mitigation of medical errors. We also recognize that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error takes place.

Identifying opportunities to reduce errors that reflect system issues are a top priority at St. Joseph Hospital and are addressed on a regular basis with the intent of identifying potential safety concerns in order to implement tactical priorities for improvement. In order to identify system failures, and safety concerns, both hospital and medical staff members need to feel comfortable in speaking up and notifying appropriate personnel to resolve the issue.

We are continuously seeking feedback on ways to improve our Patient Safety Program and encourage you to contact us with any patient safety or quality of care issues. Please leave your name and contact information if you would like follow-up or feel free to contact us anonymously.

To report a Patient Safety concern, or to receive more information, please contact the Quality Management Department representatives as listed below

Tina Retrosi, Patient Safety Officer  
St. Joseph Hospital  
714-771-8000 x.17798

Marty Jones, Director Regulatory & Accreditation  
St. Joseph Hospital  
714-771-8000 x.18244

REPORTING A QUALITY OF CARE CONCERN TO THE JOINT COMMISSION

Members of the medical staff have the right to report a concern regarding the quality or safety of treatment, care, and service rendered by the organization directly to TJC without fear of reprisal or disciplinary action.
MEDICAL STAFF EDUCATION PACKET

CERTIFICATE OF COMPLETION

I have received and reviewed the information provided as part of my annual education at
St. Joseph Hospital, Orange

ROLE IN THE EVENT OF A FIRE
RESPONDING TO INCIDENTS IN THE CARE ENVIRONMENT
ROLE IN EMERGENCY MANAGEMENT
INFECTION PREVENTION AND CONTROL
MULTI-DRUG RESISTANT ORGANISMS AND ACTIVE SCREENING
HAND HYGIENE
PREVENTING SURGICAL SITE INFECTIONS
PREVENTING CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS
PREVENTING CATHETER-ASSOCIATED URINARY TRACT INFECTIONS
PREVENTING THE TRANSMISSION OF HOSPITAL ASSOCIATED INFECTIONS
RESPIRATORY (AEROSAL TRANSMISSIBLE DISEASE) AND RASH ILLNESS AIR HANDLING SYSTEM
BIOHAZARDOUS MATERIALS MANAGEMENT
INFECTION CONTROL DURING CONSTRUCTION AND RENOVATION
USE OF RESTRAINT OR SECLUSION PAIN MANAGEMENT
PHYSICIAN IMPAIRMENT MEDICATION SAFETY ANTICOAGULANT THERAPY
DOWNTIME PROCEDURE FOR ELECTRONIC DOCUMENTATION
INFORMATION SOPHISTICATION SUPPORTING PERFECT CARE
PHYSICIAN QUICK REFERENCE GUIDE
ASSIGNING PATIENT STATUS – PROCESS/CMS REGULATIONS
HOSPICE
PATIENT SAFETY PROGRAM AND PLAN
REPORTING A QUALITY OF CARE CONCERN TO THE JOINT COMMISSION

NAME: ________________________  SIGNATURE: ________________________
DATE COMPLETED: ______________

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